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Amendment No. 1 to SB4181

Finney L
Signature of Sponsor

AMEND Senate Bill No. 4181 House Bill No. 4144*

By inserting language as a preamble immediately after the caption and before the enacting clause:

Whereas, in Tennessee, the current long-term care system for persons who are elderly and/or adults with physical disabilities is fragmented, with access to the various types of long-term care services scattered across different points of entry with no coordination between services, making it difficult for people who need care and their families to understand their options, make informed decisions, and access services in a timely manner; and

Whereas, people who need long-term care and their families have little opportunity to exercise any choice or decision-making with respect to the types of long-term care services they need and who will provide them; and

Whereas, the current long-term care system is heavily dependent on the most costly services with 98 percent of long-term care funding spent on institutional care and limited utilization of lower cost home and community-based options even though such options would better meet the needs and preferences of people who need care and their families; now, therefore,

AND FURTHER AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 14, is amended by deleting the language in § 71-5-1401 through § 71-5-1406 and § 71-5-1409 in their entirety, adding the language in SECTION 2 – SECTION 18 of this Act as new, appropriately designated sections, and renumbering remaining sections accordingly.

SECTION 2. The title of this act is, and may be cited as, the “Long Term Care Community Choices Act of 2008.”

SECTION 3. Guiding Principles of a Restructured Long-Term Care System

(a) The long-term care system shall recognize that aging is not a disease, but rather a natural process that often includes increasing needs for assistance with daily living activities. To the maximum extent possible and appropriate, the system shall be based on a model of care delivery which acknowledges that services delivered in home and community-based settings are not primarily medical in nature, but rather, support services that will provide needed assistance with activities of daily living and that will allow persons to “age in place” in their homes and communities.

(b) The long-term care system shall also recognize that persons who are elderly and/or who have physical disabilities are more likely to have chronic health care conditions and to need preventive, acute, and chronic health care services in order to promote healthy living and improve quality of life. The system shall be designed to focus on the needs of the “whole person,” with coordination of care across the continuum to ensure that medical, behavioral and non-medical long-term care support needs are met.

(c) The long-term care system shall promote independence, choice, dignity, and quality of life for elderly and/or people with physical disabilities who need long-term care supports and services and shall include consumer-directed options that offer more choices regarding the kinds of long-term care services people need, where they are provided, and who will deliver them, with appropriate mechanisms to ensure accountability for taxpayer funds.

(d) The long-term care system shall be designed to reduce fragmentation and to offer a seamless approach to meeting people’s needs, including one-stop shopping for information, counseling and assistance regarding long-term care programs in order to support informed decision making, simplified eligibility processes, and one-stop shopping for all of the different kinds of services a person may need.

(e) The long-term care system shall recognize and value the critical role of the family and other caregivers in meeting the needs of the elderly and people with physical disabilities

and shall offer services such as caregiver training, adult daycare, and respite that “wrap around” the natural support network in order to keep it in place, thereby delaying or preventing the need for more expensive, institutional care.

(f) The long-term care system shall deliver needed supports and services in the most integrated setting appropriate and cost-effective way possible in order to utilize available funding to serve as many people as possible in home and community settings.

(g) The long-term care system shall utilize a global budget for all long-term care services for persons who are elderly or who have physical disabilities that allows funding to follow the person into the most appropriate and cost-effective long-term care setting of their choice, resulting in a more equitable balance between the proportion of Medicaid long-term care expenditures for institutional (i.e., Nursing Facility) services and expenditures for home and community based services and supports.

(h) The long-term care system shall offer a continuum of long-term care services which includes an expanded array of home and community-based options including community-based residential alternatives to institutional care for persons who can no longer live alone, and which also includes nursing facility services as an integral part of the long-term care continuum for persons with the highest levels of need.

(i) The long-term care system shall include a comprehensive quality approach across the entire continuum of long-term care services and settings that promotes continuous quality improvement and that focuses on customer perceptions of quality, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues, and to improve the overall quality of services and the system.

SECTION 4. Definitions

As used in this act, unless the context otherwise requires:

(1) “Budget Allowance” means the amount of money that can be directed, utilizing the services of a fiscal intermediary, by a Medicaid-eligible long-term care member participating in this consumer-directed care option, to pay for home and community-based long-term care services defined under the Medicaid state plan or any federal waivers or amendments

thereto that are necessary to meet the member's long-term care needs and to delay or prevent institutionalization. The Budget Allowance shall be based on the results of a functional assessment performed by a qualified entity and the availability of family and other caregivers who can help provide needed support, and when combined with the cost of Home Health Services and Private Duty Nursing in the home or other community-based setting, cannot exceed the cost of institutional care;

(2) "Commissioner" means the commissioner of finance and administration or the commissioner's designee;

(3) "Cost-Effective" means that the total cost of services provided to an eligible elderly or physically disabled adult in the home or other community-based setting does not exceed the cost of reimbursement for institutional care in a nursing facility. The total cost of services shall include the cost of home health services and private duty nursing, as well as home and community based long-term care services provided pursuant to the Medicaid state plan or any federal waiver or amendments thereto.

(4) "Fiscal Intermediary" means an entity with whom the commissioner or a contractor responsible for the coordination of Medicaid primary, acute and long-term care services has contracted to help a member participating in this consumer-directed care option manage the member's budget allowance. The Fiscal Intermediary will manage all payments to providers and paid caregivers for specified home and community-based services on behalf of the member, process employment and tax information as applicable, review records to ensure accuracy and provide full accountability for all expenditures made on behalf of each participating member.

(5) "Rebalance" means reaching a more equitable balance between the proportion of Medicaid long-term care expenditures used for institutional (i.e., Nursing Facility) services and those used for home and community based services and supports under the Medicaid state plan or federal waivers or amendments thereto.

SECTION 5. Expansion of Home and Community Based Services through Implementation of a Fully Integrated Long-Term Care System

(a) The commissioner shall develop and implement a statewide fully integrated risk-based long-term care system which integrates Medicaid-reimbursed primary, acute and long-term care services, building in strong consumer protections and aligning incentives to ensure that the right care is delivered in the right place at the right time. The long term care system shall rebalance the overall allocation of funding for Medicaid-reimbursed long-term care services by expanding access to and utilization of cost-effective home and community based alternatives to institutional care for Medicaid-eligible individuals. Such system may include, subject to the availability of funding in each year's appropriations bill, expansion of PACE (Programs of All Inclusive Care for the Elderly) sites in additional major metropolitan areas of the state.

(b) The commissioner shall ensure that comprehensive, person-centered care coordination across all Medicaid primary, acute and long-term care services is a central component of the integrated long term care system and the contractor risk agreement. Care coordination shall include, but not be limited to, comprehensive individualized assessment of needs, care plan development with active participation of the member and family or other caregivers that builds on and does not supplant family and other informal caregiving supports, assurance of cost-effectiveness, and coordination and monitoring of all Medicaid primary, acute, and long-term care services to assist individuals and family or other caregivers in providing and securing necessary care.

(c) Nothing herein may be construed to create an entitlement to home and community based services, however, the commissioner shall design and implement the integrated long-term care system in a manner that affords access to cost-effective home and community based alternatives for the greatest number of Medicaid-eligible elderly and/or physically disabled individuals possible, subject to the availability of funding in each year's appropriations bill.

(d) The cost of home and community-based services provided to a Medicaid-eligible individual, which includes the cost of home health services and/or private duty nursing to the extent covered under the Medicaid program, shall not exceed the cost of institutional services for that individual in a nursing facility except as permitted under the current Medicaid state plan or any federal waivers or amendments thereto.

SECTION 6. Single Entry Point into the Long-Term Care System

The commissioner shall ensure that there is a single entry point into the long-term care system that is responsible for ensuring that persons seeking care and their families have access to readily available, easy-to understand information about long term care options. Functions performed by the single entry point may include counseling and assistance in evaluating long-term care options, screening and intake for long-term care programs, facilitated enrollment for Medicaid financial eligibility and assistance with evaluation of level of care in order to facilitate determination of medical eligibility for Medicaid long-term care services. Activities performed by the single entry point shall be conducted based on clear and consistent policies, processes and timelines in order to expedite access to available long-term care programs and services. To ensure the most seamless and efficient system possible, Medicaid eligible persons shall not be required to go back through the single entry point in order to access long-term care services, but rather, shall have a single entity that is responsible for coordinating all of the Medicaid benefits the member may need, including medical, behavioral, nursing facility, and home and community based services.

SECTION 7. Streamlined Eligibility Determination Process for Home and Community Based Services

(a) The commissioner shall implement policies and processes that expedite the determination of Medicaid categorical and financial eligibility and medical eligibility for home and community based programs and services, either through contracted functions of the department of human services or within the bureau of Tenncare. Such policies and processes may include, but are not limited to, presumptive or immediate Medicaid eligibility determination, fast track eligibility determination, development of specialized units or teams for determination of Medicaid eligibility for HCBS, implementation of facilitated enrollment processes, and the implementation of an on-line medical eligibility application process.

SECTION 8. Level of Care Criteria for Nursing Facility and Home and Community Based Services

(a) The commissioner shall develop level of care criteria for new nursing facility admissions which ensure that the most intensive level of long-term care services is provided to persons with the highest level of need.

(b) Nursing facility residents who meet continued stay criteria and who remain financially eligible for Medicaid shall continue to be eligible to receive nursing facility services or cost-effective home and community based waiver services, and shall not be required to meet new nursing facility level of care criteria.

(c) Current enrollees in the statewide home and community based services waiver program for persons who are elderly and/or adults with physical disabilities who meet continued stay criteria and remain financially eligible for Medicaid shall continue to be eligible to receive cost-effective home and community based waiver services and shall not be required to meet new nursing facility level of care criteria except for admission to a nursing facility.

(d) The commissioner shall develop and seek approval of a waiver application or amendment thereto which allows persons who meet a lesser level of care, i.e., who do not meet new nursing facility level of care criteria, but are “at risk” of institutional care, to qualify for a more moderate package of Medicaid-reimbursed home and community based waiver services up to a specified enrollment cap.

SECTION 9. Home and Community Based Services Initiative

(a) The commissioner shall develop and implement strategies to encourage the utilization of cost-effective home and community based services in lieu of institutional placement.

(b) The commissioner shall specify in contractor risk agreements with integrated long term care contractors requirements related to nursing facility diversion. Such requirements may include, but are not limited to, the following:

(1) documentation prior to approval of nursing facility admission that an individual and his/her family or other caregivers have been advised of home and community based alternatives and that such alternatives are not appropriate, cost-effective, or desired;

(2) a requirement for care coordinators to work with hospital discharge planners and to provide face-to-face visits in nursing facilities within a minimum number of days following admission to develop a plan, as appropriate, for transition back to a home or community-based setting.

SECTION 10. Nursing Facility-to-Community Transition Initiative

(a) The commissioner shall develop and implement a nursing facility transition initiative.

(b) The commissioner shall specify in contractor risk agreements with contractors responsible for coordination of Medicaid primary, acute and long-term care services requirements related to nursing facility-to-community transitions.

(c) Contractor requirements shall include identifying and assessing nursing facility residents appropriate for transition to home and community-based settings, and planning and facilitating such transitions timely. Contractors shall be permitted to coordinate or subcontract with local community based organizations to assist in the identification, planning and facilitation processes, and may offer, as a cost-effective alternative to continued institutional care, a per person transition cost allowance not to exceed two thousand dollars ($2,000) for items such as, but not limited to, first month's rent, rent and/or utility deposits, kitchen appliances, furniture and basic household items.

(d) It is the legislative intent of this section to provide more opportunities for home and community based services for the at-risk population, subject to the availability of funding in each year's appropriations bill.

SECTION 11. Nursing Facility Diversification

(a) The commissioner shall develop and implement strategies to assist nursing facilities in diversifying their lines of business, including provision of home and community based services and specialized nursing facility care to meet the targeted needs of chronic care populations.

(b) Such strategies may include, but are not limited to, provision of training and technical assistance, streamlined provider enrollment processes for home and community based services, and development of special acuity-based rates to meet the more intensive

caregiving demands of certain chronic care populations, subject to the availability of funding in each year's appropriations bill.

SECTION 12. Expansion of Cost-Effective Community-Based Residential Alternatives to Institutional Care

(a) The commissioner shall develop and implement a plan to expand cost-effective community-based residential alternatives to institutional care for persons who are elderly and/or adults with physical disabilities, which may include, but are not limited to, the development of multiple levels of assisted care living facility services, adult family care homes, adult foster care homes, companion care models, and other cost-effective residential alternatives to nursing facility care.

(b) The commissioner and the commissioner of health shall work to develop and/or modify licensure requirements for such facilities to support a nursing facility substitute framework for members who want to age in place in residences that offer increasing levels of cost-effective home and community-based care as an alternative to institutionalization as member's needs change.

SECTION 13. Nursing Facility Reimbursement

(a) The commissioner shall develop and implement an acuity-based reimbursement methodology for nursing facility services, based on an individualized assessment of need, as an alternative to the current cost-based nursing facility reimbursement system.

(b) Such methodology may include, but is not limited to, the development of enhanced rates for specified chronic care services which may encourage the establishment of chronic care units that specialize in the care of persons with specified chronic care conditions such as persons who are ventilator-dependent.

(c) The acuity-based reimbursement methodology for nursing facility services shall be implemented over a period not to exceed two (2) years, pursuant to a methodology established in regulations promulgated by the commissioner.

SECTION 14. Consumer-Directed Options

(a) The commissioner shall develop and make available consumer-directed options for persons receiving home and community-based long-term care services under the integrated long term care program, which may include but are not limited to, the ability to select, direct, and/or employ persons delivering unskilled hands-on or support services such as personal care services, personal care assistant/attendant, homemaker services, in-home respite, and the ability to manage, utilizing the services of a fiscal intermediary, an individual home and community based services budget allowance based on functional assessment performed by a qualified entity and the availability of family and other caregivers who can help provide needed support.

(b) Members eligible to receive home and community-based long term care pursuant to this act may, subject to regulations promulgated by the commissioner, be permitted to use the budget allowance to direct payment, utilizing the services of a fiscal intermediary, for those home and community based services that are necessary to meet the member's long-term care needs and to prevent and/or delay institutionalization and which are a cost-effective use of long-term care funds. Such services shall include only those services which are permitted under the Medicaid state plan or any federal waivers or amendments thereto.

SECTION 15. The commissioner shall develop and implement quality assurance and quality improvement strategies to ensure the quality of long-term care services provided pursuant to this act and shall specify in contractor risk agreements with contractors responsible for coordination of Medicaid primary, acute and long-term care services requirements related to the quality of long-term care services provided. Such strategies may include the use of electronic visit verification for data collection and reporting, HEDIS measures pertaining to long-term care services, and shall include mechanisms to ensure direct feedback from members and family or other caregivers regarding the quality of services received.

SECTION 16. Subject to the availability of funding, the commissioner shall designate in the each year's appropriations bill an amount of money, that can be used to increase access to home and community based services in the state-funded Options program for persons who do not qualify for Medicaid long-term care services. This funding may be used to provide

services such as home-delivered meals, homemaker services and personal care, and to reduce the waiting list for these services under the Options program, or to offer transportation services or assistance to non-Medicaid eligible individuals.

SECTION 17. The commissioner shall provide Medicaid long term care services subject to the availability of funding in each year's appropriations bill.

SECTION 18. The commissioner is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of the Uniform Administrative Procedures Act compiled at Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 19. Tennessee Code Annotated, Section 71-5-105(a)(3) is amended by adding the following new subdivision:

(D) Upon passage of any law authorizing the promulgation of rules establishing an acuity-based reimbursement methodology for nursing facility care, the per diem cost reimbursement methodology set forth in subdivisions (B) and (C) shall be inapplicable.

SECTION 20. Tennessee Code Annotated, Section 63-7-102, is amended by adding the following language as a new subsection:

(13) (A) Family members, friends, personal care aides and attendants who are employed by or acting at the direction of an individual receiving Medicaid-reimbursed home and community-based long-term care services that is competent to provide such direction, or at the direction of a family member or other caregiver that is competent and authorized to act on behalf of the individual receiving Medicaid-reimbursed home and community-based long-term care services, and who are acting within the scope and course of such employment and/or direction to perform routine health maintenance activities in the person's private home (which may include other alternative community-based residential settings) or in the community, when the person accompanies the individual to such settings.

(B) For the purposes of subdivision (13)(A), routine health maintenance activities are those activities which are incidental to the personal care required and which include, but are not

limited to, oral, rectal, vaginal, optic, ophthalmic, nasal, skin, topical, and transdermal administration of medications except as specified below, hydration and nutrition which may include gastrostomy tube feedings, surface care of stoma sites, and assistance with toileting which may include irrigation of catheter and bowel maintenance so long as the activity or procedure could be performed by the individual if the individual were physically capable and may be safely performed in the home or community setting. Routine health maintenance activities specifically exclude the administration of intravenous medications, sliding scale insulin, blood thinners, and controlled (scheduled) drugs, and any activity or procedure that would require the exercise of clinical judgment in order to properly perform the activity or procedure and/or to ensure the health and safety of the individual.

(C) Persons performing such tasks shall not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse.

(D) This exemption shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

SECTION 21. Tennessee Code Annotated, Section 68-11-201(4)(B), is amended by deleting the language “medical services as prescribed” and by substituting instead the language “medical services, including hospice services, as prescribed”.

SECTION 22. Tennessee Code Annotated, Section 68-11-201(4)(B)(ii), is amended by deleting the language in its entirety and by substituting instead the following language: “All other services, such as part-time or intermittent nursing care, home health aide, physical, occupational and speech therapy, medical social services, medical supplies, other than drugs and biologicals, and durable medical equipment, that a licensed home care organization is authorized to provide to homebound persons, and hospice services may be provided to a resident of an assisted-care living facility by appropriately licensed or qualified staff of the assisted-care living facility, or to the extent that the scope of services is beyond that which the assisted-care living facility is qualified or obligated to provide, a licensed home care

organization, another appropriately licensed entity, or by the appropriate licensed staff of a nursing home if the assisted-care living facility is located on the same physical campus as the licensed nursing home, in which case the assisted-care living facility shall provide the individual with written notice that such services may be available to the individual as a Medicare benefit through a licensed home care organization;

SECTION 23. Tennessee Code Annotated, Section 68-11-201(5), is amended by deleting the first paragraph in its entirety and by substituting instead the following language:

(5) "Assisted-care living facility resident" means primarily an aged ambulatory person who requires domiciliary care, and who may require one (1) or more of the services described in subdivision (4). Such resident will be transferred to a licensed hospital, licensed nursing home or other appropriate setting as ordered by the resident's treating physician when, in the opinion of the resident's treating physician, the services available to the resident in the assisted-care living facility no longer are adequate for the care of the resident. This provision shall not be interpreted as limiting the authority of the board or the department to require the transfer or discharge of individuals to different levels of care as required by statute when the resident's treating physician is not willing to certify that the resident's needs can be safely and effectively met by care provided in the assisted-care living facility pursuant to subdivision (4)(B)(ii);

SECTION 24. Tennessee Code Annotated, Section 68-11-201(5)(A), is amended by deleting the colon (":") at the end of the sentence and adding the language, "unless the person's treating physician certifies that the person's needs can be safely and effectively met by care provided in the assisted-care living facility pursuant to subdivision (4)(B)(ii):"

SECTION 25. Tennessee Code Annotated, Section 68-11-201(5)(B)(i) is amended by deleting the language in the first paragraph in its entirety and substituting instead the language, "So long as a person does not otherwise fall outside the definition of an assisted care living facility resident, the person's medical condition and overall health status are stable, the person is able to care for such person's condition with the assistance of facility personnel or care provided in the assisted-care living facility pursuant to subdivision (4)(B)(ii), and the person's treating physician certifies that the person's needs can be safely and effectively met in the

assisted-care living facility, then any assisted-care living facility may accept for admission and allow the continued stay of a person who:"

SECTION 26. Tennessee Code Annotated, Section 68-11-201(5)(B)(i)(d) is amended by deleting the language, "provided, however, with respect to this requirement, that no such documented history of self care for a person's medical condition for at least one (1) year shall be required for the continued stay of an assisted care living facility resident".

SECTION 27. Tennessee Code Annotated, Section 68-11-201(5)(B)(ii) is amended by deleting the language in its entirety and by substituting instead the language "If any resident admitted to an assisted-care living facility under subdivision (5)(B)(i) no longer meets the requirements listed above or is no longer able to self care for such resident's medical condition, and the resident's treating physician is not willing to certify that the resident's needs can be safely and effectively met by care provided in the assisted-care living facility pursuant to subdivision (4)(B)(ii), the assisted-care living facility must transfer the resident immediately to a licensed nursing home or hospital, or other appropriate setting as ordered by the resident's treating physician. Nothing in this subdivision (5)(B) shall be construed to prevent facility staff from responding to an emergency situation;"

SECTION 28. (8) Tennessee Code Annotated, Section 68-11-201(5)(B) is amended by adding the following language as a new subdivision (iii): "Notwithstanding any other provision of this subdivision (5), any assisted-care living facility resident who qualifies for hospice care may receive hospice care services and continue as a resident of the assisted-care living facility so long as the resident's treating physician certifies that the resident's needs can be safely and effectively met by care provided in the assisted-care living facility pursuant to subdivision (4)(B)(ii);"

SECTION 29. Tennessee Code Annotated, Section 68-11-201(5)(C) is amended by deleting the language in the first paragraph in its entirety and substituting instead the language, "An assisted-care living facility resident with any of the conditions listed in subdivisions (5)(C)(i)-(iii) may be retained by the facility for a period not to exceed twenty-one (21) days without certification from the resident's treating physician that the resident's needs can be safely and

effectively met by care provided in the assisted-care living facility. A resident may continue as a resident in the facility for an additional twenty-one-day period without certification from the resident's treating physician that the resident's needs can be safely and effectively met by care provided in the assisted-care living facility if, within the first twenty-one (21) days, or by the first business day thereafter if the twenty-first day is a Saturday, Sunday or holiday, or earlier if the need for an extension becomes apparent to the facility, the extension of the initial twenty-one-day period is approved by the commissioner of health, or the commissioner's designee, so long as the individual approving the extension is a physician licensed in Tennessee. The department must respond to a request for an extension of stay within five (5) working days of its receipt of a request for extension, if:".

SECTION 30. Tennessee Code Annotated, Section 68-11-201(5)(D) is deleted in its entirety, and the remaining subdivisions shall be renumbered accordingly.

SECTION 31. This act shall take effect on July 1, 2008, the public welfare requiring it.